

HealthAmerica Pennsylvania, Inc.

<http://www.healthamerica.cvty.com>

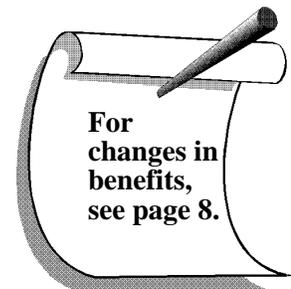


2007

A Health Maintenance Organization

Serving: *Greater Pittsburgh Area, Northwestern Pennsylvania Area, Central, Southeast & Northeast Pennsylvania*

Enrollment in this plan is limited. You must live in our Geographic service area to enroll. See page 6 for requirements.



This Plan has Excellent accreditation from NCQA. See the 2007 guide for more information on accreditation.

Enrollment codes for this Plan:

Greater Pittsburgh Area

261 High Option Self Only
262 High Option Self and Family
264 Standard Option Self Only
265 Standard Option Self and Family

Central Area

SW1 High Option Self Only
SW2 High Option Self and Family
SW4 Standard Option Self Only
SW5 Standard Option Self and Family

Southeastern Area

PN1 High Option Self Only
PN2 High Option Self and Family
PN4 Standard Option Self Only
PN5 Standard Option Self and Family

Northeastern Area

4N1 High Option Self Only
4N2 High Option Self and Family
4N4 Standard Option Self Only
4N5 Standard Option Self and Family

Important Notice About Significant Coverage Changes For Standard Option Enrollees

For 2007, HealthAmerica Standard Option enrollees must satisfy an annual deductible of \$200 under Self Only and \$400 under Self and Family. You must also pay 10% coinsurance for services, and inpatient hospitalization up to the out-of-pocket maximum. You must also pay 10% coinsurance for services, and inpatient hospitalization up to the out-of-pocket maximum so that you are aware of important changes to the coverage.

Authorized for distribution by the:



**United States
Office of Personnel Management**
Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>

Important Notice from HealthAmerica About

Our Prescription Drug Coverage and Medicare

OPM has determined that the HealthAmerica's prescription drug coverage is, on average, comparable to Medicare Part D prescription drug coverage; thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and will coordinate benefits with Medicare.

Remember: If you are an annuitant and you terminate your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D at a later date, your premium will increase 1 percent per month for each month you did not have equivalent prescription drug coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what most other people pay. You may also have to wait until the next open enrollment period to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Introduction

This brochure describes the benefits of under our contract (CS 2078) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for administrative offices is:

HealthAmerica Pennsylvania, Inc

3721 TecPort Drive PO Box 67103

Harrisburg Pa 17111

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2007, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2007, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member, “we” means.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM’s “Rate Us” feedback area at www.opm.gov/insure or e-mail OPM at fehwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM’s Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.

- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at 866-351-5946 and explain the situation.
 - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC20415-1100

- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); o
 - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That’s about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.

- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
 - Exactly what will you be doing?
 - About how long will it take?
 - What will happen after surgery
 - How can I expect to feel during recovery?
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

www.ahrq.gov/consumer/pathqpack.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

www.talkaboutrx.org/consumer.html. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1 Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

General Features of our High and Standard Options

We offer High Option coverage and Standard Option coverage. These two options of coverage provide you with a choice between lower premiums with higher out-of-pocket costs or higher premiums with lower out-of-pocket costs. If you enroll in High Option coverage, you have lower physician office visit and prescription drug copays and, you pay nothing for covered surgery or inpatient hospitalization. If you enroll in the Standard Option coverage, you must satisfy an annual deductible of \$200 per Self Only enrollment or \$400 per Self and Family enrollment. After you have satisfied the Standard Option annual deductible, you simply pay 10% coinsurance for covered surgical procedures and inpatient hospitalization up to the out-of-pocket maximum of \$1,000 under Self Only and \$2,000 under Self and Family. The Standard Option coverage affords you protection from catastrophic illness because there is a limit to your out-of-pocket costs for covered care. After you have met the out-of-pocket maximum under the Standard Option coverage, we eliminate the coinsurance that you are required to pay for most covered procedures. Please note that you must still make copayments for covered office visits and prescription drugs. We will not apply the annual deductible to your annual out-of-pocket limit.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance. Our providers are paid on a capitated basis or a fee for service basis according to negotiated contracts. We do not participate in any withholds/bonus or incentive programs.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- We are compliant with Federal and state licensing requirements. We have been a licensed HMO since 1975
- We have been in existence for over 30 years.
- We are a for-profit HMO.
- We have participated with the FEHB program since 1977.

If you want more information about us, call (866) 351-5946 or write to 3721 TecPort Drive, PO Box 67103, Harrisburg PA 17111. You may also contact us by visiting our Web site at www.healthamerica.cvty.com.

Service Area

To enroll in this Plan, you must live in our Service Area. You must enroll in the code for the county in which you live. This is where our providers practice. Our service area is divided into four enrollment codes, 26, 4N, SW, and PN.

Enrollment code 26 (Greater Pittsburgh area) includes the following Pennsylvania counties: Allegheny, Armstrong, Beaver, Bedford, Butler, Cambria, Cameron, Clarion, Crawford, Erie, Elk, Fayette, Forest, Greene, Jefferson, Indiana, Lawrence, McKean, Mercer, Somerset, Venango, Warren, Washington, and Westmoreland.

Enrollment code SW (Central area) includes the following Pennsylvania counties: Adams, Berks, Blair, Centre, Clearfield, Clinton, Columbia, Cumberland, Dauphin, Franklin, Huntingdon, Juniata, Lancaster, Lebanon, Lehigh, Lycoming, Mifflin, Montour, Northampton, Northumberland, Perry, Schuylkill, Snyder, Union and York.

Enrollment code 4N (Northeastern area) includes the following Pennsylvania counties: Carbon, Lackawanna, Luzerne, Monroe, Pike, Susquehanna, Wayne and Wyoming.

Enrollment code PN (Southeast area) includes the following Pennsylvania counties: Bucks, Chester, Delaware, Montgomery and Philadelphia.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member moves outside of our service area, you can enroll in another plan. If your dependents live out of the area, you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you have a dependent student who is a full-time student, temporarily attending school out of state, we do offer limited coverage through this plan. See page 44. If you or a family member moves, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2 How we changed for 2007

Do not rely on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Changes to this Plan

Changes to both High and Standard Options

- We have added Bucks, Montgomery, and Philadelphia County to enrollment code PN. Please see page 6 for a complete description of our service area.
- Under the Prescription Drug Benefits, we have reduced your copay for generic formulary drugs from \$8 to \$5 for up to a 31-day or 100 unit supply (whichever is less) of covered medication. You may obtain up to a 90-day supply of covered generic formulary medication for \$10. See page 42.

Changes to High Option only

- For enrollment code 26, your share of the High Option non-Postal premium will increase by 16.9% for Self Only or 13.7% for Self and Family.
- For enrollment code SW, your share of the High Option non-Postal premium will increase by 22.2% for Self Only coverage and 22% for Self and Family coverage.
- For enrollment code 4N, your share of the High Option non-Postal premium will increase by 59.3% for Self Only coverage and 58.5% for Self and Family coverage.
- For enrollment code PN, your share of the High Option non-Postal premium will increase by 46.2% for Self Only coverage and 45.5% for Self and Family coverage.

Changes to Standard Option only

- For enrollment code 26, your share of the Standard Option non-Postal premium will decrease by 5.7% for Self Only or 22.3% for Self and Family.
- For enrollment code SW, your share of the Standard Option non-Postal premium will increase by 15.2% for Self Only or 15.1% for Self and Family.
- For enrollment code 4N, your share of the Standard Option non-Postal premium will increase by 7.2% for Self Only and 7.3% for Self and Family.
- For enrollment code PN, your share of the Standard Option non-Postal premium will increase by 40.6% for Self Only and 44.4% for Self and Family.
- You must satisfy an annual deductible of \$200 for Self only enrollment and \$400 for Self and Family enrollment before we provide benefits for covered services such as outpatient hospital services, inpatient hospitalization, and surgery. See Section 4 *Your cost for covered services* on page 12.
- After you have satisfied the annual deduction, you are responsible for paying 10% coinsurance for covered services provided by participating facilities and providers. See Section 5.
- We limit your out of pocket cost (excluding the deductible) for covered services to \$1,000 for Self Only enrollment and \$2,000 for Self and Family enrollment. See Section 4 *Your cost for covered services* on page 12.

Section 3. How you get care

Identification cards We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system such as Employee Express confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at (866) 351-5946 or you may request replacement cards through our Web site at www.healthamerica.cvty.com.

Where you get covered care You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, deductibles, and/or coinsurance.

- **Plan providers** Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site at www.healthamerica.cvty.com or call the plan.

- **Plan facilities** Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Web site at www.healthamerica.cvty.com.

What you must do to get covered care It depends on the type of care you need. First you and each family members must choose a primary care physician (PCP). This decision is important since your primary care physician provides or arranges for most of your health care. You can complete a PCP Selection care and mail it or you can call us.

- **Primary care** Your Primary Care Physician can be a family practitioner, internist or a pediatrician. Your Primary Care Physician will provide most of your health care, or coordinate your care to see a specialist. If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.
- **Specialty care** Our plan does not require you to obtain referrals to see specialists, however the provider must be in our network. If you go to a non-participating provider, benefits will be denied, except for Emergency services and Urgent Care Services outside of the Service Area and certain referrals as provided below.

Here are some other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your physician will work with us to develop a treatment plan that allows you to continue seeing your specialist. Your physician will use our criteria when creating your treatment plan. The participating network provider may have to get our prior approval for certain services.
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

- If you have a chronic and disabling condition and lose access to your specialist because we:

Terminate our contract with your specialist for other than cause; or

Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or

Reduce our service area and you enroll in another FEHB Plan,

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

• **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at (866)351-5946. If you are new to the FEHB Program, we will arrange for you to receive care.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

Services requiring our prior approval

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. The following are health care services which require pre-certification:

- Inpatient hospital admissions
- Extended Care/Skilled Nursing Facility
- Outpatient surgeries
- Bariatric surgery for morbid obesity
- Home health care
- Durable medical equipment
- Out of network referral requests
- Transplant requests
- Complex diagnostic testing such as Magnetic Resonance Imaging,
- Infertility treatment

- Growth Hormone Therapy (GHT)
- Mental Health and Substance Abuse treatment *
- Pain management programs
- Genetic Testing
- Hospice Care
- Cardiac Rehabilitation

* You must contact United Behavioral Health before seeking mental health and substance abuse treatment. United Behavioral Health will help develop a treatment plan that you must follow. We will not cover services that United Behavioral Health has not approved.

Section 4 Your costs for covered services

This is what you will pay out-of-pocket for covered care.

Copayments

A co-payment (or copay) is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

High Option example: when you see your primary care physician, you pay a co-payment of \$10 per office visit and when you visit a specialist the co-payment is \$25 per visit.

Standard Option example: when you see your primary care physician you pay a co-payment of \$20 per office visit—and when you visit a specialist the co-payment is \$30.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them under the Standard Option coverage.

Copayments under the Standard Option coverage do not count toward the deductible. The High Option coverage does not have a deductible.

- The calendar year deductible is \$200 per person under Self Only enrollment and \$400 per Self and Family enrollment. Under family coverage, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach \$400.

Note: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for covered care. Under the Standard Option Coverage, coinsurance doesn't begin until you have satisfied your deductible.

High Option example: In our High Option, you pay \$300 or 50% of our allowance (whichever is less) for covered infertility services.

Standard Option example: Under the Standard Option, you pay 10% after you have satisfied your deductible for covered inpatient hospitalization.

Your catastrophic protection out-of-pocket maximum

High Option: We limit your out-of-pocket expenses for covered services under this plan to the stated copayments and coinsurance required for some benefits.

Standard Option: After the coinsurance that you pay for covered services totals \$1,000 per person or \$2,000 per family in a calendar year, you no longer have to pay coinsurance. Your annual out-of-pocket maximum does not include deductibles or copayments for office visits (or other covered care) and prescription drugs. It also does not include amounts that you pay for non-covered services.

Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum.

Carryover

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Section 5 High and Standard Option Benefits

See page 8 for how our benefits changed this year. Page 67 and page 68 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5 High and Standard Option Benefits Overview

This Plan offers a High Option. Our benefit package is described in Section 5. Make sure that you review the benefits carefully.

The High Option Section 5 is divided into subsections. Please read the important things you should keep in mind at the beginning of the subsections. Also read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filling advice, or more information about High Option benefits, contact us at (866) 351-5946 or at our Web site at www.healthamerica.cvty.com.

Each option offers the following unique features:

High Option

- No calendar year deductible
- Annual out-of-pocket expenses are limited to specific copays and coinsurance for a few covered services
- \$10 per primary care office visit and \$25 per visit to a specialist
- Nothing for laboratory tests such as blood tests, urinalysis, and pap tests
- \$25 for each X-ray, CT Scan/MRI, or Ultrasound
- Nothing for covered inpatient hospital care
- Nothing for the physician's charges for surgery
- \$75 copay per visit for accidental injury or medical emergency room treatment at a hospital
- Prescription Drug copays of \$5 for generic formulary, \$25 name brand formulary, and \$40 non-formulary

Standard Option

- Annual deductible of \$200 Self Only and \$400 Self and Family (applies to all services except office visits)
- Annual out-of-pocket expenses are limited to \$1,000 per person or \$2,000 per Self and Family enrollment
- \$10 Well child office visit to primary care office.
- \$20 per primary care office visit and \$30 per visit to a specialist
- Nothing for laboratory tests such as blood tests, urinalysis, and pap tests
- \$40 for each X-ray, CT Scan/MRI, or Ultrasound
- 10% for covered inpatient hospital care after the annual deductible
- 10% for the physician's charges for covered surgery after the annual deductible
- \$100 copay per visit for accidental injury or medical emergency room treatment at a hospital
- Prescription Drug copays of \$5 for generic formulary, \$35 name brand formulary, and \$50 non-formulary

**Section 5(a) Medical services and supplies
provided by physicians and other health care professionals**

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Under the Standard Option coverage, coinsurance applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- We do not have a deductible under High Option. Under the Standard Option, the calendar year deductible is: \$200 per person (\$400 per family). The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply. Copayments for office visits do not count toward the calendar year deductible or out-of-pocket maximum.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year deductible...	
<p>Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say “(No deductible)” when it does not apply. You do not have a calendar year deductible if you are enrolled in the High Option.</p>		
Diagnostic and treatment services	High Option	Standard Option
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office • Office medical consultations • Second surgical opinion 	\$10 per office visit to your primary care physician \$25 per office visit to a specialist	\$20 per office visit to your primary care physician \$30 per office visit to a specialist (No deductible)
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • During a hospital stay • In a skilled nursing facility 	Nothing	Nothing
At home	\$10 per visit from your primary care physician \$25 per visit from a specialist	\$20 per visit from your primary care physician \$30 per visit from a specialist (No deductible)
Lab, X-ray and other diagnostic tests	High Option	Standard Option
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • Non-routine mammograms 	Nothing	Nothing

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
Lab, X-ray and other diagnostic tests (cont.)		
Prenatal ultrasound	\$25 per visit	Nothing
<ul style="list-style-type: none"> • X-rays • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	\$25 per visit	\$40 per visit (No deductible)
Preventive care, adult	High Option	Standard Option
Routine screenings, such as:	Nothing if you receive these services during your office visit; otherwise	Nothing if you receive these services during your office visit; otherwise
<ul style="list-style-type: none"> • Total Blood Cholesterol - once every 3 years • Colorectal Cancer Screening, including <ul style="list-style-type: none"> - Fecal occult blood test - Double contrast barium enema - Colonoscopy screening 	\$10 per office visit to your primary care physician \$25 per office visit to a specialist	\$20 per office visit to your primary care physician \$30 per office visit to a specialist (No deductible)
Sigmoidoscopy, screening – every five years starting at age 50	Nothing	Nothing
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing	Nothing
Routine Pap test Note: You do not pay a separate copay for a Pap test performed during your routine annual physical; see <i>Diagnostic and treatment services</i> .	\$10 per office visit to your primary care physician \$25 per office visit to a specialist	\$20 per office visit to your primary care physician \$30 per office visit to a specialist (No deductible)
Routine mammogram – covered for women age 35 and older, as follows:	Nothing	Nothing (No deductible)
<ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • One per calendar year age 40 and above 		
Routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC):	\$10 per office visit to your primary care physician \$25 per office visit to a specialist	\$20 per office visit to your primary care physician \$30 per office visit to a specialist (No deductible)
<ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccines, annually, age 50 and over at physicians discretion for those determined to be high risk. • Pneumococcal vaccine, age 65 and over 		
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges.</i>	<i>All charges.</i>

Benefit Description	You pay After the calendar year deductible...	
Preventive care, children	High Option	Standard Option
<ul style="list-style-type: none"> Childhood immunizations recommended by the American Academy of Pediatrics 	\$10 per office visit to your primary care physician \$25 per office visit to a specialist	\$10 per office visit to your primary care physician \$30 per office visit to a specialist (No deductible)
<ul style="list-style-type: none"> Well-child care charges for routine examinations, immunizations and care (up to age 22) Examinations, such as: <ul style="list-style-type: none"> Eye exams through age 17 to determine the need for vision correction Ear exams through age 17 to determine the need for hearing correction Examinations done on the day of immunizations (up to age 22) 	\$10 per office visit to your primary care physician \$25 per office visit to a specialist	\$10 per office visit to your primary care physician \$30 per office visit to a specialist (No deductible)
Maternity care	High Option	Standard Option
Complete maternity (obstetrical) care, such as: <ul style="list-style-type: none"> Prenatal care Delivery Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary (you do not need to pre-certify the normal length of stay). We will extend your inpatient stay for you or you baby if medically necessary. We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	\$10 per office visit to your primary care physician \$25 per office visit to a specialist Note: You pay the office visit copay for your first visit only. We waive the office visit copay after your initial maternity care visit.	\$20 per office visit to your primary care physician \$30 per office visit to a specialist Note: You pay the office visit copay for your first visit only. We waive the office visit copay thereafter for normal routine maternity care visits. We will apply the annual deductible and 10% coinsurance to the physician and the facility charges for delivery.
<i>Not covered: Routine sonograms to determine fetal age, size, or sex.</i>	<i>All charges.</i>	<i>All charges.</i>

Benefit Description	You pay After the calendar year deductible...	
Family planning	High Option	Standard Option
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs) • Diaphragm fitting <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>\$10 per office visit to your primary care physician</p> <p>\$25 per office visit to a specialist</p>	<p>\$20 per office visit to your primary care physician</p> <p>\$30 per office visit to a specialist</p> <p>(No deductible)</p>
<ul style="list-style-type: none"> • Voluntary sterilization 	<p>\$50 per vasectomy</p> <p>\$100 per tubal ligation</p>	<p>\$50 per vasectomy</p> <p>\$100 per tubal ligation</p> <p>(No deductible)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Infertility services	High Option	Standard Option
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) 	<p>\$300 copay per member or 50% of the cost of the service, whichever is less</p>	<p>\$300 copay per member or 50% of the cost of the service, whichever is less</p> <p>(No deductible)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>In vitro fertilization</i> - <i>embryo transfer,</i> - <i>gamete intra-fallopian transfer (GIFT) and</i> - <i>zygote intra-fallopian transfer(ZIFT)</i> • <i>Services and supplies related to ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
Allergy care		
<ul style="list-style-type: none"> • Testing and treatment 	\$10 per office visit to your primary care physician \$25 per office visit to a specialist	\$20 per office visit to your primary care physician \$30 per office visit to a specialist (No deductible)
<ul style="list-style-type: none"> • Allergy serum • Allergy injections 	Nothing	Nothing (No deductible)
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Provocative food testing</i> • <i>Sublingual allergy desensitization</i> 	<i>All charges.</i>	<i>All charges.</i>
Treatment therapies	High Option	Standard Option
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page xx.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: We will only cover GHT when we preauthorize the treatment and determine that it is medically necessary. Your doctor will need to submit medical information to support that GHT is medically necessary. You must obtain authorization for GHT before you begin treatment because we only cover GHT services from the date we determine it is medically necessary. We do not cover GHT or related services and supplies if we determine it isn't medically necessary. See <i>Services requiring our prior approval</i> in Section 3.</p>	\$10 per office visit to your primary care physician \$25 per office visit to a specialist	\$20 per office visit to your Primary Care Physician \$30 per office visit to a Specialist Note: You will owe 10% coinsurance after you have satisfied the annual deductible for all outpatient facility services.

Benefit Description	You pay After the calendar year deductible...	
Physical and occupational therapies	High Option	Standard Option
<p>Up to two consecutive months per condition for the services of each of the following:</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury and if significant improvement can be expected within two consecutive months.</p> <ul style="list-style-type: none"> • Cardiac rehabilitation is limited to treatment for therapy conditions that in the judgment of a participating physician and the Medical Director are subject to significant improvement through short-term therapy. We will only cover one course of cardiac rehabilitation per episode. 	<p>\$10 per office visit to your Primary Care Physician</p> <p>\$25 per office visit to a Specialist</p> <p>Nothing per visit if services are provided by a participating Physical Therapist</p> <p>Nothing per visit during covered inpatient admission.</p>	<p>10% coinsurance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Long-term rehabilitative therapy • Exercise programs 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Speech therapy	High Option	Standard Option
<p>Up to two consecutive months per condition for the services provided by a qualified speech therapist</p>	<p>\$10 per office visit to Primary Care Physician</p> <p>\$25 per office visit to a Specialist</p> <p>Nothing per visit during covered inpatient admission.</p>	<p>10% coinsurance</p>
Hearing services (testing, treatment, and supplies)	High Option	Standard Option
<ul style="list-style-type: none"> • Hearing testing (one per contract year) 	<p>\$10 per office visit to your Primary Care Physician</p> <p>\$25 per office visit to a Specialist</p>	<p>\$20 per office visit to Primary Care Physician</p> <p>\$30 per visit to a Specialist</p> <p>(No deductible)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • All other hearing testing • Hearing aids, testing and examinations for them 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Benefit Description	You pay After the calendar year deductible...	
Vision services (testing, treatment, and supplies)	High Option	Standard Option
<ul style="list-style-type: none"> One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) 	Nothing	Nothing
<ul style="list-style-type: none"> Annual eye refractions for all members under High Option only Under the Standard Option, we cover annual eye refractions for children only up to the age of 18. We do not cover eye refractions for anyone over the age of 18. <p>Note: See Non-FEHB Program benefits for additional vision services. See page 48.</p> <p>Note: To find a Cole Managed Vision provider near you, visit our website at www.healthamerica.cvty.com or call member services at 1-866-351-5946.</p>	\$15 per office visit	\$15 per office visit up to age 18. (No deductible)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Eyeglasses or contact lenses</i> <i>Eye exercises and orthoptics</i> <i>Radial keratotomy and other refractive surgery</i> 	<i>All charges.</i>	<i>All charges.</i>
Foot care	High Option	Standard Option
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See the “<i>Not covered</i>” section under orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	\$10 per office visit to your Primary Care Physician \$25 per office visit to a Specialist	\$20 per office visit to your Primary Care Physician \$30 per office visit to a Specialist (No deductible)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> 	<i>All charges.</i>	<i>All charges.</i>

Benefit Description	You pay After the calendar year deductible...	
Orthopedic and prosthetic devices	High Option	Standard Option
<ul style="list-style-type: none"> • Artificial limbs and eyes • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, limbs, pacemakers, and surgically implanted breast implant following mastectomy, when authorized in accordance with the plan’s policies and procedures. Note: See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome when rheumatoid arthritis, ankylosing spondylitis, or disseminated lupus erythmatosus. <p>Note: You must receive our preauthorization. Call us at (866) 351-5946 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	Nothing	10% coinsurance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> • <i>Foot orthotics (except for diabetics)</i> • <i>Heel pads and heel cups</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>Cochlear implant devices</i> • <i>Replacement due to neglect</i> • <i>Any dental care involved with the treatment of tempormandibular joint (TMJ) pain dysfunction syndrome or joint disorders</i> • <i>Dental prosthesis</i> • <i>Lumbar supports</i> • <i>Wigs</i> 	<i>All charges.</i>	<i>All charges.</i>

Benefit Description	You pay After the calendar year deductible...	
Durable medical equipment (DME)	High Option	Standard Option
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> • Oxygen; • Dialysis equipment; • Hospital beds; • Wheelchairs; • Crutches; • Walkers; • Blood glucose monitors; and • Insulin pumps. <p>Note: You must receive our preauthorization. Call us at (866) 351-5946 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	Nothing	10% coinsurance
<ul style="list-style-type: none"> • Diabetes equipment such as blood glucose monitors, insulin infusion devices, and orthotic (for diabetics only) 	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Disposable items such as incontinent pads, catheters, irrigation kits, electrodes, ace bandages, elastic stockings, and dressings</i> • <i>Equipment which serves for comfort or convenience functions or is primarily for the convenience of a person caring for a member</i> • <i>Air conditioners</i> • <i>Corrective appliances that do not require prescription specifications or are used primarily for recreational sports</i> • <i>Humidifiers</i> • <i>Electric air cleaners</i> • <i>Exercise or fitness equipment</i> • <i>Elevators</i> • <i>Hot tubs</i> • <i>Hoyer lifts</i> • <i>Shower/bath bench</i> • <i>Routine servicing, e.g., testing, cleaning, regulating and checking of equipment</i> • <i>Special clothing of any type</i> • <i>Hearing devices of any type</i> 	<i>All charges.</i>	<i>All charges.</i>

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
Durable medical equipment (DME) (cont.)		
<ul style="list-style-type: none"> • <i>Replacement due to neglect</i> 	<i>All charges.</i>	<i>All charges.</i>
Home health services		
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. 	Nothing	10% coinsurance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i> • <i>Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication</i> • <i>Homemaker services</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</i> • <i>Services or supplies furnished by a person who is the spouse or relative of member or by non home health provider</i> 	<i>All charges.</i>	<i>All charges.</i>
Medical Foods		
<ul style="list-style-type: none"> • Services for nutritional formulas as medically necessary for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria as administered under the direction of a Participating Provider • Elemental Formula: Prior authorization is required. Covered services according to Plan guidelines for formulas made up of single amino acids and simple sugars and if the following requirements are met. <ul style="list-style-type: none"> - You must require nutritional therapy to sustain life (that is, to meet 505 of your daily nutritional requirements); and - Adequate nutrition must not be possible with dietary adjustment and/ or oral supplements. <p>Note: We will only cover medical foods when we authorize the services. Your Physician must see you within thirty (30) days before to begin the Prior Authorization process and any subsequent re-Authorization.</p>	Nothing	Nothing (No deductible)
<p><i>Not covered:</i></p>	<i>All charges.</i>	<i>All charges.</i>

Medical Foods - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Medical Foods (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Food or food supplements, vitamins or other nutritional and over-the-counter electrolyte supplements except as specified above • Services that we have not authorized 	<i>All charges.</i>	<i>All charges.</i>
Chiropractic	High Option	Standard Option
<p>Up to 15 visits per calendar year for :</p> <ul style="list-style-type: none"> • Manipulation of the spine and extremities or • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application 	\$25 per office visit	\$30 per office visit (No deductible)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Visits that exceed 15 per calendar year 	<i>All charges.</i>	<i>All charges.</i>
Alternative treatments	High Option	Standard Option
<p>Biofeedback when approved in conjunction with an approved pain management program or for the treatment of urinary and or fecal incontinence.</p>	<p>\$10 per office visit to your Primary Care Physician</p> <p>\$25 per office visit to a Specialist</p>	10% coinsurance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Naturopathic services • Hypnotherapy • Acupuncture • Biofeedback services not shown as covered 	<i>All charges.</i>	<i>All charges.</i>
Educational classes and programs	High Option	Standard Option
<p>Outpatient diabetes self-management training and education (including nutritional therapy) for persons with diabetes, when prescribed by a Plan Physician. Coverage includes:</p> <ul style="list-style-type: none"> • visits that are medically necessary upon the diagnosis of diabetes; • visits where a Plan physician identifies and diagnoses a significant change in the patient's symptoms or conditions that necessitates changes in a patient's self-management; and • visits where a licensed physician identifies that a new medication or therapeutic process relating to the person's treatment or diabetes management is medically necessary. 	<p>\$10 per office visit to your Primary Care Physician</p> <p>\$25 per office visit to a Specialist</p>	<p>\$20 per office visit to your Primary Care Physician</p> <p>\$30 per office visit to a Specialist</p> <p>(No deductible)</p>

Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care
- We do not have a deductible under High Option. Under the Standard Option, the calendar year deductible is: \$200 per person (\$400 per family). The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply. Copayments for office visits do not count toward the calendar year deductible or out-of-pocket maximum.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the pre-certification information shown in Section 3 to be sure which services require pre-certification and identify which surgeries require pre-certification.

Benefit Description	You pay After the calendar year deductible...	
<p>Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say “(No deductible)” when it does not apply. You do not have a calendar year deductible if you are enrolled in the High Option.</p>		
Surgical procedures	High Option	Standard Option
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see <i>Reconstructive surgery</i>) • Insertion of internal prosthetic devices . See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information • Treatment of burns • Circumcision of newborn males <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	<p>Nothing</p>	<p>10% coinsurance</p>

Surgical procedures - continued on next page
High and Standard Option Section 5(b)

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
Surgical procedures (cont.)		
Voluntary sterilization (such as tubal ligation and vasectomy)	\$50 copay for vasectomy or \$100 copay for tubal ligation	\$50 copay for vasectomy or \$100 copay for tubal ligation
<ul style="list-style-type: none"> Surgical treatment of morbid obesity (bariatric surgery) <p>Note: We cover medically necessary bariatric surgery if you are age 18 or over. We limit the covered bariatric surgery procedures to gastroplasty (gastric stapling) or roux-en-y gastric bypass (Roux-en-Y). Your physician must obtain preauthorization of the surgery. We will cover the surgery in our preferred network of Bariatric Centers of Excellence. We will not cover care outside our Bariatric Centers of Excellence unless we specifically authorize it. Please contact us for our complete medical policy. You must satisfy all of the following criteria.</p> <ul style="list-style-type: none"> Body mass index (BMI) more than 40 or BMI greater than 35 with documented co morbid conditions such as cardiopulmonary problems (e.g., severe apnea), Pickwickian Syndrome, obesity-related cardiomyopathy, severe diabetes mellitus, hypertension, or arthritis. Morbid obesity has persisted more than 3 years and there is no treatable metabolic cause for obesity. Failure to lose weight or has regained weight after participation in a 3 month physician supervised program within the past six months that included dietary therapy, physical activity and behavior therapy and support. Completion of a psychological evaluation and surgical clearance by a cardiologist and pulmonologist. Commitment to participate in a multidisciplinary program that will provide guidance on diet, physical activity, and social support. 	Nothing	10% coinsurance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Reversal of voluntary sterilization</i> <i>Routine treatment of conditions of the foot; see Foot care</i> <i>Cosmetic procedures</i> 	<i>All charges.</i>	<i>All charges.</i>

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
<p>Reconstructive surgery</p> <ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymph edemas; - breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	Nothing	10% coinsurance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> 	<i>All charges.</i>	<i>All charges.</i>
<p>Oral and maxillofacial surgery</p> <p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate; • Excisions of lesions of the mandible, mouth, lip, or tongue • Incision of accessory sinuses, mouth, salivary glands, or duct; • Manipulation of dislocations of the jaw; 	Nothing	10% coinsurance

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Oral and maxillofacial surgery (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Reconstruction or repair of the mouth or lis necessary to correct functional impairment caused by congenital condition and birth abnormalities; • Treatment of tumors; • Extraction of impacted third molars when partially or totally covered by bone; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. 	Nothing	10% coinsurance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> • <i>Orthodontia</i> • <i>Treatment of TMJ if dental related</i> • <i>Orthognathic or prognatic surgery when it is performed only to improve the appearance of a functioning structure</i> 	<i>All charges.</i>	<i>All charges.</i>
Organ/tissue transplants	High Option	Standard Option
<p>Note: Transplant services must be performed at a participating Center of Excellence. We approve and designate where all transplants must be performed including hospitals for specific transplant procedures. If you would like to know about a specific facility, please contact Customer Service.</p> <p>Note: We cover related medical and hospital expenses of donor when the expenses are not covered by the donor’s insurance and when the transplant recipient is a HealthAmerica member approved for transplant services.</p> <p>Solid organ transplants imited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Liver • Pancreas* • Kidney/Pancreas 	Nothing	10% coinsurance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
<p>Organ/tissue transplants (cont.)</p> <ul style="list-style-type: none"> • Lung: single, double, lobar • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas <p>* We limit coverage for pancreas (only) transplants to patients who have insulin dependent (or Type 1) diabetes mellitus when we find that exogenous treatment with insulin is ineffective.</p>	Nothing	10% coinsurance
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses. The medical necessity is considered satisfied if the patient meets the staging description.</p> <p>Allogeneic (donor) transplants for:</p> <ul style="list-style-type: none"> • chronic myelogenous leukemia • acute lymphocytic or non-lymphocytic leukemia • severe or very severe aplastic anemia • severe combined immuno-deficiency disease • phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • advanced Hodgkin’s lymphoma • advanced non-Hodgkin’s lymphomas <p>Autologous (self) bone marrow transplants (autologous stem cell and peripheral stem cell support) for:</p> <ul style="list-style-type: none"> • acute lymphocytic or non-lymphocytic leukemia • advanced Hodgkin’s lymphoma • advanced non-Hodgkin’s lymphomas • advanced neuroblastoma • testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors • breast cancer • multiple myeloma • epithelial ovarian cancer <p>Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer)</p>	Nothing	10% coinsurance
<p>Blood or marrow stem cell transplants in randomized and controlled Phase III clinical trials for the treatment of cancer that are sanctioned by the National Cancer Institute (NCI), limited to:</p> <p>Allogeneic (donor) transplants for:</p> <ul style="list-style-type: none"> • chronic lymphocytic leukemia 	Nothing	10% coinsurance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • early stage (indolent or non-advanced) small cell lymphocytic lymphoma • multiple myeloma • advanced neuroblastoma • advanced myelodysplastic syndromes (e.g, DeNovo, secondary, high dose) not previously treated • infantile malignant osteopetrosis • mucopolipidosis (e.g., adrenoleukodystrophy) • mucopolysaccharidosis (e.g., Hurler’s syndrome, Maroteaux-Lamy syndrome variants) • chronic and juvenile myelomonocytic leukemia <p>Nonmyeloablative allogeneic transplants for:</p> <ul style="list-style-type: none"> • acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • advanced forms of myelodysplastic syndromes • advanced Hodgkin’s lymphoma • advanced non-Hodgkin’s lymphoma • breast cancer • chronic lymphocytic leukemia • chronic myelogenous leukemia • colon cancer • early stage (indolent or non-advanced) small cell lymphocytic lymphoma • multiple myeloma • myeloproliferative disorders • non-small cell lung cancer • ovarian cancer • prostate cancer • renal cell carcinoma • sarcomas <p>Autologous transplants for:</p> <ul style="list-style-type: none"> • chronic lymphocytic leukemia • chronic myelogenous leukemia • early stage (indolent or non-advanced) small cell lymphocytic lymphoma • multiple sclerosis • systemic lupus erythematosus • systemic sclerosis • amyloidosis (single) 	<p>Nothing</p>	<p>10% coinsurance</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	High Option	Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Donor expenses related to donating organs or tissue to a non-member recipient. • Implants of artificial organs • Transplants not specifically listed as covered 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Anesthesia	High Option	Standard Option
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center 	<p>Nothing</p>	<p>10% coinsurance</p>
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Office 	<p>\$10 per office visit to your Primary Care Physician</p> <p>\$25 per office visit to a Specialist</p>	<p>\$20 per office visit to your Primary Care Physician</p> <p>\$30 per office visit to a Specialist</p> <p>(No deductible)</p>

Section 5(c) Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We do not have a deductible under High Option. Under the Standard Option, the calendar year deductible is: \$200 per person (\$400 per family). The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply. Copayments do not count toward the calendar year deductible or out-of-pocket maximum.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require pre-certification.

Benefit Description	You pay	
<p>Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say “(No deductible)” when it does not apply. You do not have a calendar year deductible if you are enrolled in the High Option.</p>		
Inpatient hospital	High Option	Standard Option
<p>Room and board, such as</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	Nothing	10% coinsurance
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma if not donated or replaced • Dressings , splints , casts , and sterile tray services • Medical supplies and equipment, including oxygen 	Nothing	10% coinsurance
<ul style="list-style-type: none"> • Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	Nothing	10% coinsurance

Benefit Description	You pay	
	High Option	Standard Option
<p>Inpatient hospital (cont.)</p> <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Private nursing care except when medically necessary 	<i>All charges.</i>	<i>All charges.</i>
<p>Outpatient hospital or ambulatory surgical center</p> <ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma • Blood and blood plasma, if not donated or replaced • Packed red blood cells, cryoprecipitate, Factor VII, and platelets; • Other clotting factors or blood components such as Factor VIII or Factor IX, whether naturally or artificially derived are covered for acute traumatic events or when medically necessary. • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedure itself.</p>	Nothing	10% coinsurance
<p><i>Not covered: Blood and blood derivatives not replaced by the member</i></p>	<i>All charges.</i>	<i>All charges.</i>
<p>Extended care benefits/Skilled nursing care facility benefits</p> <p>Skilled nursing facility (SNF) or Extended care benefits:</p> <p>Up to 100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by us. Services include:</p> <ul style="list-style-type: none"> • Bed, board and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor 	Nothing	10% coinsurance

Extended care benefits/Skilled nursing care facility benefits - continued on next page

Benefit Description	You pay	
Extended care benefits/Skilled nursing care facility benefits (cont.)	High Option	Standard Option
<i>Not covered: Custodial care rest cures, domiciliary, or convalescent care</i>	<i>All charges.</i>	<i>All charges.</i>
Hospice care	High Option	Standard Option
Supportive and palliative care for a terminally ill member is covered in the home or a hospice facility. Services include inpatient and outpatient care, and family counseling. Hospice services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.	Nothing	10% coinsurance
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges.</i>	<i>All charges.</i>
Ambulance	High Option	Standard Option
Local professional ambulance service when medically appropriate	Nothing	10% coinsurances

Section 5(d) Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We do not have a deductible under High Option. Under the Standard Option, the calendar year deductible is: \$200 per person (\$400 per family). The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply. Copayments do not count toward the calendar year deductible or out-of-pocket maximum.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

Emergencies within or outside our service area

If you experience the sudden onset of a medical condition or injury with symptoms that you think may result in serious impairment, please go to the nearest emergency room or call 911. Otherwise if your symptoms allow, call your Primary Care Physician. Your primary care physician is available to advise you about an urgent or emergency situation 24 hours a day, seven days a week by phone. Your PCP's phone number is on your ID card. Be sure to call your Primary Care Physician before going to a hospital emergency room or urgent care center whenever possible. If it is not possible, go straight to the nearest hospital emergency room or call 911 or the local emergency phone number. Be sure to tell the emergency room personnel that you are a HealthAmerica Plan member. Please be sure that you contact your PCP within 24 hours of being treated or admitted. Your PCP will make sure that:

- Medical information about you is given to the hospital emergency room doctor;
- Your care continues without delay; and
- Your follow-up care is coordinated.

If you are outside the service area and a Plan doctor believes that your care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full. To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Benefit Description	You pay After the calendar year deductible...	
<p>Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say “(No deductible)” when it does not apply. You do not have a calendar year deductible if you are enrolled in the High Option.</p>		
Emergency within our service area	High Option	Standard Option
<ul style="list-style-type: none"> Emergency care at your primary care doctor’s office 	\$10 per office visit	\$20 per office visit (No deductible)
<ul style="list-style-type: none"> Emergency care at a specialist's office 	\$25 per office visit	\$30 per office visit (No deductible)
<ul style="list-style-type: none"> Emergency care as an outpatient at a hospital or urgent care center , including doctors’ services <p>Note: We waive the ER copay if you are admitted to the hospital.</p>	\$75 per visit	\$100 per visit (No deductible)
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges.</i>	<i>All charges.</i>
Emergency outside our service area	High Option	Standard Option
<ul style="list-style-type: none"> Emergency care at a doctor’s office 	\$10 per office visit	\$20 per office visit (No deductible)
<ul style="list-style-type: none"> Emergency care at a specialist’s office 	\$25 per office visit	\$30 per office visit to a specialist (No deductible)
<ul style="list-style-type: none"> Emergency care as an outpatient at a hospital or urgent care center, including doctors’ services <p>Note: We waive the ER copay if you are admitted to the hospital.</p>	\$75 per visit	\$100 per visit (No deductible)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers</i> <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges.</i>	<i>All charges.</i>
Ambulance	High Option	Standard Option
<p>Professional ambulance service when medically appropriate.</p> <p>Note: See 5(c) for non-emergency service.</p>	Nothing	10% coinsurance

Section 5(e) Mental health and substance abuse benefits

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must use participating providers.
- We do not have a deductible under High Option. Under the Standard Option, the calendar year deductible is: \$200 per person (\$400 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply. Copayments do not count toward the calendar year deductible or out-of-pocket maximum.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay After the calendar year deductible...	
<p>Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when it does not apply. You do not have a calendar year deductible if you are enrolled in the High Option.</p>		
Mental health and substance abuse benefits	High Option	Standard Option
<p>All diagnostic and treatment services recommended by a provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management <p>Note: Psychiatrists, psychologists, or licensed clinical social workers are specialty providers. The office visit copay of specialists applies to services from these providers.</p>	<p>\$10 per office visit to your Primary Care Physician or</p> <p>\$25 per office visit to a Specialist or</p> <p>Nothing for inpatient services</p>	<p>\$20 per office visit to your Primary Care Physician or</p> <p>\$30 per office visit to a Specialist or</p> <p>(No deductible)</p>
<p>The following diagnostic tests:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Pathology 	<p>\$10 per office visit to your Primary Care Physician</p> <p>\$25 per office visit to a Specialist</p>	<p>\$20 per office visit to your Primary Care Physician</p> <p>\$30 per office visit to a Specialist</p>

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
Mental health and substance abuse benefits (cont.)		
	Nothing for inpatient services	(No deductible)
The following diagnostic tests including but not limited to: <ul style="list-style-type: none"> • X-rays • CT Scans • Ultrasound • Electrocardiogram 	\$25 copay per visit	\$40 copay per visit (No deductible)
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	Nothing	10% coinsurance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Services we have not approved.</i> • <i>Evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate.</i> • <i>Testing for learning disabilities, school related issues, or for the purposes of obtaining or maintaining employment.</i> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<i>All charges.</i>	<i>All charges.</i>

Preauthorization

To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following authorization processes:

United Behavioral Health will coordinate your Mental Health and Substance Abuse services. If you need help, call your Primary Care Physician. Your doctor will work with United Behavioral Health to coordinate the care that you need. You may also call United Behavioral Health directly without referral from your Primary Care Physician.

If you need to seek mental health care services on an emergency basis, United Behavioral Health is available to you 24 hours a day, 7 days a week. Their normal business hours are from 8:00 am to 6:00 pm. You can reach United Behavioral Health toll free at (866) 369-8362, TDD (877) 266-2099.

We have a comprehensive network of professionals and facilities available for mental health and chemical dependency treatment. Please refer to the list of providers in the Mental Health/Chemical Dependency section of your Provider Directory. If you need a directory or assistance with finding a provider call (866) 351-5946.

Limitation

We may limit your benefits if you do not obtain a treatment plan.

Section 5(f) Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on page 43.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We do not have a deductible under High Option. The Standard Option annual calendar year deductible does not apply to the prescription drug benefits. Copayments that you pay for covered prescription medication do not count toward the calendar year deductible or out-of-pocket maximum.
- Selected products and certain prescription drugs require our prior approval. In general, drugs that require our prior approval (1) are not suggested for first-line therapy, (2) require special tests before starting them, or (3) have very limited approval for use.
- **Be sure to read Section 4, *Your costs for covered services, for valuable information about how cost sharing works.*** Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician or referral plan doctor must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a local Plan participating pharmacy or by mail at our participating mail-order pharmacy for a plan-approved maintenance medication. Our Plan pharmacies are listed in our directory.
- **We use a formulary.** Our Prescription Drug Formulary is a list of drugs and other items that we approve for your use and which will be dispensed through participating pharmacies to members. We periodically review and modify our formulary. The list of approved drugs is available for review in the participating physician's office. You may also obtain them formulary list by contacting the Plan's Member Services Department or our website at www.healthamerica.cvty.com. We cover non-formulary drugs prescribed by a Plan doctor.
- **These are the dispensing limitations.** You may obtain up to a 31-day supply or 100-unit supply; whichever is less, at a Plan Participating retail pharmacy. For commercially prepackaged drugs such as topicals, inhalers, and vials, you will pay one copay for each container. Selected products or prescription drugs may require prior approval from the Plan. These medications may include those that (1) are not suggested for first-line therapy, (2) may require special tests before starting them, (3) have very limited approval for use, or (4) have specific quantity limits. Sexual dysfunction drugs have specific quantity limitations. When generic substitution is permissible, but you or your doctor choose the name brand drug over the generic drug, you pay the price difference between the generic drug and name brand drug as well as the appropriate copay per prescription unit or refill. Your prescription drug copay will never exceed the retail price of the drug. Plan members called to active military duty (or members in time of national crisis) who need to obtain prescribed medications should call us at 866-351-5946.
- **Prescriptions by Mail-order.** You can order up to a 3-month supply of approved maintenance medications through the mail and pay just two times the retail pharmacy copay. For commercially prepackaged drugs such as topicals, inhalers, and vials, you will pay one mail order copay for each three (3) containers. Maintenance medications are those that you must take for long-term conditions such as high blood pressure or high cholesterol. Simply ask your doctor to write your maintenance medication prescription for up to a 90-day supply. You will need to complete a mail order envelope (which you can obtain from Member Services) and mail it to the address on the front of the envelope. All maintenance medications are not available by mail-order. For a list of maintenance medications that you can obtain by mail, please contact us at (866) 351-5946.
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name. The name brand is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you – and us – less than a name brand prescription.

- When you do have to file a claim.** Prescription drugs prescribed for emergency services and filled by a Non-Participating pharmacy are covered only for a quantity sufficient to treat the acute phase of the illness/injury. Coverage for such prescription Drugs prescribed in relation to Emergency Services and provided by a Non-Participating pharmacy is limited to one hundred percent (100%) of the Reasonable and Customary Charge less applicable copayments and other appropriate charges as noted above such as when a brand drug is dispensed and an FDA approved generic is available. Members must submit claims for reimbursement of prescription drugs purchased from a Non-Participating pharmacy on a Direct Reimbursement Form (available from HealthAmerica’s Member Services Department). All claims for reimbursement must be received by HealthAmerica or its agent within ninety (90) days of the date of purchase of the prescription drugs. Claim forms are also available from our website (www.healthamerica.cvty.com) under the Downloadable Rx Forms Section.

Benefit Description	You pay After the calendar year deductible...	
Covered medications and supplies	High Option	Standard Option
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as Not Covered. Full range of FDA approved contraceptives, including but not limited to oral, injectable or implantable contraceptives and contraceptive diaphragms Insulin with a charge and copay for each vial Plan approved diabetic supplies and pharmacological agents, or devices used to assist in insulin injection (injection aids) including insulin syringes and needles, blood glucose test strips and lancets Disposable needles and syringes for the administration of covered medications Self administered- injectable drugs (see note below). <p>Note: Self administered injectables include but are not limited to multiple sclerosis agents, colony stimulating factors, chronic medications for hepatitis C, rheumatoid medication, certain HIV drugs, osteoporosis agents, heparin products, etc. You cannot obtain a 90- day supply of these drugs and they are not available through our mail-order pharmacy. These agents require prior authorization and must be filled at our contracted or participating Specialty Pharmacy. This does not apply to Insulin, Glucagon, Bee Sting Kits (Antigen) and Imitrex.</p> <ul style="list-style-type: none"> Growth hormone therapy (see note below) 	<p>At a Plan Retail Pharmacy:</p> <p>\$5 copay for generic formulary,</p> <p>\$25 copay for name brand formulary,</p> <p>\$40 copay non-formulary</p> <p>or</p> <p>Through our Mail Order Pharmacy:</p> <p>\$10 copay for generic,</p> <p>\$50 copay brand,</p> <p>\$80 copay for non-formulary</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p> <p>Note: For commercial containers through mail order, you pay the appropriate copay for each (3) containers.</p>	<p>At a Plan Retail Pharmacy:</p> <p>\$5 copay for generic formulary,</p> <p>\$35 copay for name brand formulary,</p> <p>\$50 copay non-formulary</p> <p>or</p> <p>Through our Mail Order Pharmacy:</p> <p>\$10 copay for generic,</p> <p>\$70 copay brand,</p> <p>\$100 copay for non-formulary</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p> <p>Note: For commercial containers through mail order, you pay the appropriate copay for each (3) containers.</p>

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Covered medications and supplies (cont.)	High Option	Standard Option
<p>Note: We will only cover GHT when we preauthorize the treatment and determine that it is medically necessary. Your doctor will need to submit medical information to support that GHT is medically necessary. You must obtain authorization for GHT before you begin treatment because we only cover GHT services from the date we determine it is medically necessary. <i>See services requiring our prior approval</i> in Section 3. You cannot obtain a 90- day supply of GHT and it is not available through our mail-order pharmacy.</p> <p>Note: Please check section 5(a) when checking coverage for intravenous fluids and medications for home use, some injectable drugs, diabetic equipment (glucose monitor) and some FDA approved contraceptive devices.</p>	<p>At a Plan Retail Pharmacy:</p> <p>\$5 copay for generic formulary,</p> <p>\$25 copay for name brand formulary,</p> <p>\$40 copay non-formulary</p> <p>or</p> <p>Through our Mail Order Pharmacy:</p> <p>\$10 copay for generic,</p> <p>\$50 copay brand,</p> <p>\$80 copay for non-formulary</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p> <p>Note: For commercial containers through mail order, you pay the appropriate copay for each (3) containers.</p>	<p>At a Plan Retail Pharmacy:</p> <p>\$5 copay for generic formulary,</p> <p>\$35 copay for name brand formulary,</p> <p>\$50 copay non-formulary</p> <p>or</p> <p>Through our Mail Order Pharmacy:</p> <p>\$10 copay for generic,</p> <p>\$70 copay brand,</p> <p>\$100 copay for non-formulary</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p> <p>Note: For commercial containers through mail order, you pay the appropriate copay for each (3) containers.</p>
<ul style="list-style-type: none"> • Drugs for sexual dysfunction are subject to dose or quantity limitations. If it comes in pill form the limit is 4 pills per month, or 6 units per month for injectables or suppositories. Call the Plan for specific dose limitations . <p>Note: These drugs are not available by mail-order.</p>	<p>At a Plan Pharmacy</p> <p>\$40 copay</p>	<p>At a Plan Pharmacy</p> <p>\$50 copay</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, and minerals (both OTC and legend), except legend prenatal vitamins and liquid or chewable legend pediatric vitamins</i> • <i>Supplies such as dressings and antiseptics</i> • <i>Drugs to aid in smoking cessation</i> • <i>Drugs used for the primary purpose of treating infertility, including those given in connection with artificial insemination</i> • <i>Oral dental preparations and fluoride rinses</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Covered medications and supplies (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • <i>Drug therapy for weight loss (e.g. Xenical)</i> • <i>Nonprescription medicines</i> • <i>Drugs for investigational and experimental purposes</i> • <i>Food or food supplements, other nutritional and over-the-counter electrolyte supplements.</i> 	<i>All charges.</i>	<i>All charges.</i>

Section 5(g) Special features

Feature	Description
Flexible Benefits Option	Under the flexible benefits option, we determine the most effective way to provide services. We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. Alternative benefits are subject to our ongoing review. By approving an alternative benefit, we cannot guarantee you will get it in the future. The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Services for deaf and hearing impaired	Telecommunications Device for the Deaf and hearing impaired members who have access to a TDD-Compatible telephone. Members call (800) 207-1262 from 7 am - 6 pm Monday- Friday or from 9 am - 1 pm on Saturday.
Complex case management	Complex Case Management programs promote quality of care to reduce the likelihood of extended, more costly health care. Our specially trained nurse case managers work directly with the patients and their doctors. Some of the programs include Cardiovascular, Endocrinology, Oncology, Trauma/Medical-Surgical.
High risk pregnancies	This program is set up to identify women at risk for developing complications that may affect their pregnancy. The program promotes quality of care to reduce the likelihood of extended, more costly health care and focus on patients at risk, early intervention, coordination of care between patient and health care team, continuing education and regular follow up to ensure the patient is following the plan of care properly. For more information call (866) 351-5946.
Centers of excellence	HealthAmerica has a nationally recognized organ transplant network through Coventry's Transplant Centers of Excellence to coordinate care for members who may need a transplant. The network provides you and your family with access to the hospitals across the country, which specialize in specific transplant procedures. For information and access to these Centers of Excellence call Member Services. Care provided outside the Centers of Excellence network will not be covered unless approved by the Plan.
Student out-of-area coverage	<p>Limited coverage is available to dependent students up to the age of 22 who:</p> <ul style="list-style-type: none"> • are the dependents of Federal Government subscribers who live in the HealthAmerica service area. • attend a secondary school, college, university or licensed trade school full time; (must submit a copy of schedule or a letter from the school stating the students full time status and • temporarily live outside Pennsylvania, but in the USA for the purpose of attending school;

Feature - continued on next page

Feature	Description
Feature (cont.)	
	<p>This limited benefit provides coverage outside Pennsylvania at non-participating providers for the treatment of an unexpected illness or injury. Covered benefits include such things as: emergency care, physician services for illness and injury, outpatient rehabilitation, diabetic education and training, therapeutic injections, dialysis, lab, radiology, durable medical equipment and corrective appliances, allergy serum and services, initial doctor visit to diagnose a pregnancy. Some benefits require authorization.</p> <p>Benefits Not Covered:</p> <p>Any benefit not listed above as a covered benefit; any benefit no considered to be medically necessary; elective care service. Additionally, mental health and substance abuse services must be provided by a participating provider. When in the HealthAmerica service area, students must use participating providers. Dependent student coverage is subject to the Exclusions and Limitations as outlined in this brochure. If you have questions please contact the plan at 1-866-351-5946.</p>

Section 5(h) Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We do not have a deductible under High Option. Under the Standard Option, the calendar year deductible is: \$200 per person (\$400 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply. Copayments do not count toward the calendar year deductible.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- **Be sure to read Section 4, *Your costs for covered services, for valuable information about how cost sharing works.*** Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay	
Accidental injury benefit	High Option	Standard Option
<p>We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. We will only cover services that you receive within 24 hours of the accident.</p> <p>Note: We do not cover services rendered more than 24 hours after the accidental injury whether or not the treatment is a continuation or completion of a treatment plan initiated at time of injury.</p>	Nothing	10% coinsurance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Services provided after the initial 24 hours post</i> • <i>Orthodontia and all other dental related services</i> • <i>Services provided by non-participating dentists</i> • <i>Other dental services shown as not covered.</i> 	<i>All charges.</i>	<i>All charges.</i>
Dental Benefits	High Option	Standard Option
<i>We have no other dental benefits.</i>	<i>All charges.</i>	<i>All charges.</i>

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums.

Dental Care

We offer a dental program to HealthAmerica members. Please review the dental carrier brochure for details.

Vision Coverage

Cole's Vision One Eye care Program offers immediate savings on your eye care needs including eyeglass frames and lenses. There are thousands of Cole Managed Vision network providers including Sears Optical, Target Optical, Pearle Vision, JCPenny Optical and select Independent Doctors of Optometry.

Kids Health -

This program helps families make informed decisions about children's health. Includes age-appropriate content for parents, kids & teens.

Global Fitness Program

Global Fit Fitness Program allows members to join premier fitness clubs at substantially discounted rates.

Health Education Classes

—

Classes include Weight Management, Diabetic Education, Prenatal Education,

Stress Management and Smoking Cessation. You can be reimbursed up to \$150 per calendar year for the Weight Watchers program when you have attended 80% of the meetings.

To obtain an approved listing of programs available or request a provider directory, call our customer service department at (866) 351-5946. Or you can receive additional information regarding any of our programs by accessing the HealthAmerica website at www.healthamerica.cvtv.com.

Section 6 General exclusions – things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.**

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7 Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at (866) 351-5946.

When you must file a claim – such as for services you received outside the Plan’s service area – submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member’s name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

If you are in enrollment code SW, 4N, and PN, submit your claims to:

Harrisburg - HealthAmerica, Attn: Member Services Department, PO Box 7088, London, KY 40742

If you are in enrollment code 26, submit your claims to:

Pittsburgh - HealthAmerica, Attn: Member Services Department, PO Box 7088, London, KY 40742

Prescription drugs

You must complete a claim reimbursement form. Contact the plan at (866) 351-5946.

Other supplies or services

Submit your claims to:

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond.

Section 8 The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval required by Section 3.

1

Ask us in writing to reconsider our initial decision. You must:

- a. Write to us within 6 months from the date of our decision; and
- b. Send your request to us at the address below which is based on your enrollment code:

Central, Northeast, and Southeast Region (SW, 4N, PN)

HealthAmerica, Attn: Member Services Department,

3721 TecPort Drive

P.O. Box 67103

Harrisburg, PA 17106

or

Greater

Pittsburgh and Northwest Region (26)

HealthAmerica, Attn: Member Services Department,

Cranberry Business Park

120 East Kensingler

Cranberry Township, PA 16066 ;

and

- c. Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
- d. Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

2

We have 30 days from the date we receive your request to:

- a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or
- b) Write to you and maintain our denial - go to step 4; or
- c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.

3

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.

4

If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

5

OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at (866)-351-5946, and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM's Health Insurance Group 3 at 202/606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9 Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member have coverage under any other health plan or have automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age or older;
- Some people with disabilities under 65 years of age; and
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

• Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It’s easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. Tell us if you are enrolled in Medicare part A or B. Medicare will determine who is responsible for paying first for medical services. If Medicare pays first, we coordinate our payment for covered services as long as you use providers that are part of our network. Under your FEHB coverage, we do not waive any of the copayments.

Claims process when you have the Original Medicare Plan

You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payer, we process the claim first.

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at (866) 351-5946 or see our Web site at www.healthamerica.cvt.com.

We do not waive any costs if the Original Medicare Plan is your primary payer.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and our Medicare Advantage plan: You may enroll in our Medicare Advantage plan and also remain enrolled in our FEHB plan. In this case, we do not waive any of our copayments, coinsurance, or deductibles for your FEHB coverage

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but **we will not waive any of our copayments, coinsurance, or deductibles.** If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you?	The primary payer for the individual with Medicare is?	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #1 above	✓	
4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and • You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
5) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓ *	
B. When you or a covered family member?		
1) Have Medicare solely based on end stage renal disease (ESRD) and • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and • This Plan was the primary payer before eligibility due to ESRD		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you?		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse		
	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

**TRICARE and
CHAMPVA**

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

Workers' Compensation

We do not cover services that:

- You need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

**When others are
responsible for your care**

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

**When others are
responsible for your
injuries**

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

Section 10 Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 12.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 12.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial Care	Care provided by non-medical personnel that does not attempt to cure your condition but will help you perform daily living activities. Some examples of custodial care include helping you walk, dress, bathe, eat or take your medication.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 12.
Experimental or investigational service	We gather appropriate information to determine whether a procedure, service, or supply is experimental or investigational. The gathered information includes all appropriate medical records, reviews of current medical and scientific evidence publications, as well as information from government regulatory bodies. Appropriate medical professionals participate in the extensive evaluation process to determine whether a procedure is/is not considered experimental or investigational. After the determination is made, you will be notified of our decision. You can obtain a copy of our Experimental procedures Determinations Policy by contacting the plan.
Group health coverage	Group health coverage is protection that provides payment of benefits for covered sickness or injury.
Medical necessity	A service or treatment which is appropriate and consistent with diagnoses, and which in accordance with accepted standards of practice in the medical community of the area in which the health services are rendered, could not have been omitted without adversely affecting the member's condition or the quality of medical care rendered.
Morbid Obesity	A body mass index (BMI) more than 40 or a BMI greater than 35 with documented co morbid conditions such as cardiopulmonary problems (e.g., severe apnea), Pickwickian Syndrome, obesity-related cardiomyopathy, severe diabetes mellitus, hypertension, or arthritis.
Out-of-pocket maximum	The out-of-pocket maximum is an annual limit on the amount of coinsurance that you must pay for covered services. This limit does not include office visit or prescription drug copays.
Plan allowance	Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. When services are received at participating providers, payment will be made to the provider for services rendered, based on the contract we have with the provider.
Us/We	Us and We refer to HealthAmerica Pennsylvania, Inc.
You	You refers to the enrollee and each covered family member.
Primary Care Physician	Primary Care Physician (PCP) is a family practitioner, internist or a pediatrician. Your PCP can provide most of your routine care and will manage your preventive care.

Section 11 FEHB Facts

Coverage information

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status, divorcé, or when your child under age 22 marries.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2007 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2006 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

When FEHB coverage ends

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

Upon divorce

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide To Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

Temporary Continuation of Coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

Converting to individual coverage

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at www.opm.gov/insure/health; refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 12 Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB Program.

Second, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket.

Third, the new **Federal Employees Dental and Vision Insurance Program (FEDVIP)**, offers a variety of dental plans and vision plans to anyone who is eligible to enroll in the Federal Employees Health Benefits Program. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents. Premiums are on an enrollee-pays-all basis

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

Why should you consider applying for coverage under the **Federal Long Term Care Insurance Program (FLTCIP)**?

- **FEHB plans do not cover the cost of long term care.** Also called “custodial care,” long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums. If you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions about your health. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.
- **To request an Information Kit and application.** Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses.

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$250 and a maximum annual election of \$5,000.

- **Health Care FSA (HCFSA)** – Pays for eligible health care expenses for you and your dependents which are not covered or reimbursed by FEHBP coverage or other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents, which are not covered or reimbursed, by FEHBP or FEDVIP coverage or other insurance.
- **Dependent Care FSA (DCFSA)** – Pays for eligible dependent care expenses that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.

What expenses can I pay with an FSAFEDS account?

For the HCFSA – Health plan copayments, deductibles, over-the-counter medications and products, sunscreen, eyeglasses, contacts, other vision and dental expenses (but not insurance premiums).

For the LEX HCFSA– Dental and vision care expenses including eligible over-the-counter medicines and products related to dental and vision care (but not insurance premiums).

For the DCFSA – Daycare expenses (including summer camp) for your child(ren) under age 13, dependent care expenses for dependents unable to care for themselves.

AND MUCH MORE! Visit www.FSAFEDS.com.

Who is eligible to enroll?

Most Federal employees in the Executive branch and many in non-Executive branch agencies are eligible. For specifics on eligibility, visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

When can I enroll?

If you wish to participate, you must make an election to enroll each year by visiting www.FSAFEDS.com or calling the number above during the FEHB Open Season or within 60 days of employment (for new employees).

Even if you enrolled for 2006, you must make a new election to continue participating in 2007. Enrollment DOES NOT carry over from year to year.

Who is SHPS?

SHPS is the Third Party Administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is BENEFEDS?

BENEFEDS is the name of the voluntary benefits portal hired by OPM to work with the FSAFEDS Program to set up payroll deductions for FSAFEDS allotments.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a new program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004.

OPM has contracted with several insurance carriers to make supplemental dental and vision benefits available to eligible Federal and USPS employees, annuitants, and their eligible family members.

Dental Insurance

Dental plans will provide a comprehensive range of services, including the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.

- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with a 24-month waiting period

Please review the dental plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

Vision Insurance

Vision plans will provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Please review the vision plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

What plans are available?

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/dentalvision. This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

Premiums

The premiums will vary by plan and by enrollment type (self, self plus one, or self and family). There is no government contribution to the premiums. If you are an active employee, your premiums will be taken from your salary on a pre-tax basis when your salary is sufficient to make the premium withholding. If you are an annuitant, premiums will be withheld from your monthly annuity check when your annuity is sufficient. Pre-tax premiums are not available to annuitants. For information on each plan's specific premiums, visit www.opm.gov/insure/dentalvision.

Who is eligible to enroll?

Federal and Postal Service employees eligible for FEHB coverage (whether or not enrolled) and annuitants (regardless of FEHB status) are eligible to enroll in a dental plan and/or a vision plan.

Enrollment types available

- Self-only, which covers only the enrolled employee or annuitant;
- Self plus one, which covers the enrolled employee or annuitant plus one eligible family member specified by the enrollee; and
- Self and family, which covers the enrolled employee or annuitant and all eligible family members.

Which family members are eligible to enroll?

Eligible family members include your spouse, unmarried dependent children under age 22, and unmarried dependent children age 22 or over incapable of self-support because of a mental or physical disability that existed before age 22.

When can I enroll?

Eligible employees and annuitants can enroll in a dental and/or vision plan during this open season -- November 13 to December 11, 2006. You can enroll, disenroll, or change your enrollment during subsequent annual open seasons, or because of a qualified life event. New employees will have 60 days from their first eligibility date to enroll.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. BENEFEDS is a secure enrollment website sponsored by OPM where you enter your name, personal information like address and Social Security Number, the agency you work for (or retirement plan that pays your annuity), and the dental and/or vision plan you select. For those without access to a computer, call 1-877-888- FEDS (TTY number, 1-877-TTY-5680). If you do not have access to a computer or a phone, contact your employing office or retirement system for guidance on how to enroll.

You cannot enroll in a FEDVIP plan using the Health Benefits Election Form (SF 2809) or through an agency self-service system, such as Employee Express, MyPay, or Employee Personal Page. However, those sites may provide a link to BENEFEDS.

When will coverage be effective?

The new Program will be effective December 31, 2006. Coverage for those who enroll during this year's open season (November 13 – December 11, 2006) will be effective December 31, 2006. Coverage for any other enrollments will be effective on/or after December 31, 2006.

How does this coverage work with my FEHB plan's dental or vision coverage?

Some FEHB plans already cover some dental and vision services. When you are covered by more than one health/dental plan, federal law permits your insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered expenses.

Coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

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Summary of benefits for the High Option of the HealthAmerica Pennsylvania, Inc.- 2007

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Below, an asterisk (*) means the item is subject to the \$xx calendar year deductible.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: \$10 primary care; \$25 specialist	17
Services provided by a hospital:		
• Inpatient	Nothing	35-36
• Outpatient	Nothing	36
Emergency benefits:		
• In-area	\$75 per urgent care center or hospital emergency room visit	39
• Out-of-area	\$75 per urgent care center or hospital emergency room visit	39
Mental health and substance abuse treatment:		
	Regular cost sharing	40-41
Prescription drugs:		
		42-45
• Retail pharmacy	\$5 generic formulary; \$25 name brand fomulary; \$40 non-formulary per prescription unit or refill	43-45
• Mail order	\$10 generic formulary; \$50 name brand formulary; \$80 non-formulary	43-45
Dental care: Accidental injury benefit only for care rendered within 24 hours		
	Nothing	48
Vision care: Limited to one annual eye refraction		
	\$15 per office visit	22
Special features: High risk pregnancy, Centers of Excellence, Member services TDD, Complex Case Management		
		46-47
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Summary of benefits for the Standard Option of HealthAmerica Pennsylvania, Inc. - 2007

- Do not rely on this chart alone. All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- Below, an asterisk (*) means the item is subject to the \$xx calendar year deductible.

Standard Option Benefits	You Pay	You Pay
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: \$20 primary care; \$30 specialist	17
Services provided by a hospital:		
• Inpatient	10% coinsurance	35-36
• Outpatient	10% coinsurance	36
Emergency benefits:		38-39
• In-area	\$100 per urgent care center or hospital emergency room visit	39
• Out-of-area	\$100 per urgent care center or hospital emergency room visit	39
Mental health and substance abuse treatment:	Regular cost sharing	40-41
Prescription drugs:		42-45
• Retail pharmacy	\$5 generic formulary; \$35 name brand formulary; \$50 non-formulary	43-44
• Mail order	\$10 generic formulary; \$70 name brand formulary; \$10 non-formulary	43-44
Dental care: Accidental injury benefit only for care rendered within 24 hours	10% coinsurance	48
Vision care: Limited to one annual eye refraction for children up to age 18 only	\$15 per office visit	22
Special features: High risk pregnancy; Centers of Excellence; Member Services TDD, Complex Case Management		46
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after \$1,000 Self only or \$2,000 Self and Family Some costs do not count toward this protection.	12

2007 Rate Information for - HealthAmerica Pennsylvania Inc.

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable FEHB Guide.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share

Greater Pittsburgh Area

High Option Self Only	261	\$141.92	\$ 58.55	\$307.49	\$126.86	\$167.54	\$ 32.93
High Option Self and Family	262	\$321.89	\$189.32	\$697.43	\$410.19	\$380.01	\$131.20
Standard Option Self Only	264	\$127.65	\$ 42.55	\$276.58	\$ 92.19	\$151.05	\$ 19.15
Standard Option Self and Family	265	\$321.89	\$112.11	\$697.43	\$242.90	\$380.01	\$ 53.99

Central Pennsylvania

High Option Self Only	SW1	\$141.92	\$109.75	\$307.49	\$237.80	\$167.54	\$84.13
High Option Self and Family	SW2	\$321.89	\$256.95	\$697.43	\$556.72	\$380.01	\$198.83
Standard Option Self Only	SW4	\$141.92	\$ 75.62	\$307.49	\$163.85	\$167.54	\$ 50.00
Standard Option Self and Family	SW5	\$321.89	\$178.46	\$697.43	\$386.66	\$380.01	\$120.34

Northeastern Pennsylvania

High Option Self Only	4N1	\$141.92	\$172.72	\$307.49	\$374.23	\$167.54	\$147.10
High Option Self and Family	4N2	\$321.89	\$401.78	\$697.43	\$870.52	\$380.01	\$343.66
Standard Option Self Only	4N4	\$141.92	\$112.33	\$307.49	\$243.39	\$167.54	\$ 86.71
Standard Option Self and Family	4N5	\$321.89	\$262.87	\$697.43	\$569.55	\$380.01	\$204.75

Southeastern Pennsylvania

High Option Self Only	PN1	\$141.92	\$100.00	\$307.49	\$216.67	\$167.54	\$ 74.38
High Option Self and Family	PN2	\$321.89	\$233.58	\$697.43	\$506.09	\$380.01	\$175.46

Standard Option Self Only	PN4	\$141.92	\$ 63.37	\$307.49	\$137.31	\$167.54	\$ 37.75
Standard Option Self and Family	PN5	\$321.89	\$149.44	\$697.43	\$323.79	\$380.01	\$ 91.32